ARUP LABORATORIES

A nonprofit enterprise of the University of Utah and its Department of Pathology

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THIS IS NOT A TEST REQUEST FORM. Please complete and submit with the test request form or electronic packing list.

VON WILLEBRAND (VWD) TESTING PATIENT HISTORY FORM

Patient Name: _____ **Date of Birth:** _____ **Sex:** ☐ Female ☐ Male

Ordering Provider: _____ **Provider's Phone:** _____

Practice Specialty: _____ **Provider's Fax:** _____

Genetic Counselor: _____ **Counselor's Phone:** _____

Patient's Ethnicity/Ancestry (check all that apply)

☐ African American/Black ☐ Asian ☐ Hispanic ☐ White ☐ Other: _____

List country of origin (if known): _____

Does the patient have a suspected diagnosis of VWD? ☐ No ☐ Yes (specify type below) ☐ Unknown

☐ Type 1 ☐ Type 2A ☐ Type 2B ☐ Type 2M ☐ Type 2N ☐ Type 3 ☐ Pseudo VWD ☐ Acquired VWD

Does the patient have symptoms? ☐ No ☐ Yes (check all that apply) ☐ Unknown

☐ Excessive bruising	☐ Hematuria	☐ Prolonged bleeding after childbirth
☐ Gastrointestinal bleeding	☐ Intracranial hemorrhage	☐ Prolonged bleeding post-surgery
☐ Hemarthrosis	☐ Menorrhagia	☐ Prolonged repeated nosebleeds
☐ Hematomas	☐ Post tooth extraction bleeding	☐ Other symptom(s): _____

Indicate disease severity in the patient: ☐ NA ☐ Mild ☐ Moderate ☐ Severe ☐ Unknown

Laboratory Findings—Hemostasis factor assays:

Factor VIII:	_____%	☐ Normal	☐ Low	☐ Unknown	☐ Not performed
VWF: RCo (ristocetin cofactor activity)	_____%	☐ Normal	☐ Low	☐ Unknown	☐ Not performed
VWF: Ag (quantity of antigen)	_____%	☐ Normal	☐ Low	☐ Unknown	☐ Not performed
VWF: CB (collagen binding)	_____%	☐ Normal	☐ Abnormal	☐ Unknown	☐ Not performed
VWF: FVIIIB (Factor VIII binding)		☐ Normal	☐ Abnormal	☐ Unknown	☐ Not performed
RIPA: Ristocetin-induced platelet agglutination		☐ Normal	☐ Abnormal	☐ Unknown	☐ Not performed
VWF Multimer Pattern		☐ Normal	☐ Abnormal (describe: _____)		

Has the patient undergone previous DNA testing? ☐ No ☐ Yes ☐ Unknown

If yes, describe the test(s) and results: _____

Is there any relevant family history? ☐ No ☐ Yes ☐ Unknown

If yes, attach a pedigree or specify the relative's relationship to the patient. List their symptoms and age of onset:

Has DNA testing been performed for the family member(s)? ☐ No ☐ Yes ☐ Unknown

If yes, attach a copy of the relative's DNA laboratory result (REQUIRED for familial mutation testing).

Check the test you intend to order.

☐ **3004379 von Willebrand Disease (VWF) Sequencing:** Clinical sensitivity 80% for VWD type 1 and 90% for VWD types 2 and 3.

☐ **2001961 Familial Mutation, Targeted Sequencing:** Tests for a sequence variant previously identified in a family member; a copy of a relative's lab result is REQUIRED

Master Label

For questions, contact an ARUP genetic counselor at 800-242-2787 ext. 2141.